STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00188701. This visit resulted in a partially extended survey- Immediate Jeopardy. Complaint IN00188701- Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey date: December 28, 2015 Extended Survey date: December 29, 2015 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census bed type: SNF/NF: 56 Total: 56 Census payor type: Medicare: 8 Medicaid: 43 Other: 5 Total: 56 Sample: 3 Extended sample: 3 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on January 4, 2015.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 1	F 323		

environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on record review, interview and observation, the facility failed to ensure a resident who was established as a known elopement risk was provided adequate supervision to prevent elopement which resulted in the resident leaving the facility through an alarmed door for 1 of 3 residents reviewed for elopement. This was related to the failure of staff to complete every 2 hours observation rounds and the failure to ensure staff followed protocol by turning off the alarming exit door and not notifying other charge staff when no residents or staff members were observed outside of the exit door. The resident was last seen at 6:30 p.m. and discovered missing at 9:45 p.m. This resulted in an Immediate Jeopardy.

This deficiency resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 11/25/15 when Resident #D exited the facility unsupervised and was not identified as missing after the exit alarm sounded at 8:30 p.m. and was turned off. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 12/28/15 at 2:40 p.m. The Immediate Jeopardy was removed, and the deficient practice was corrected on 12/6/15, prior to the start of the survey and was therefore Past Noncompliance.

Finding includes:

The closed record for Resident #D was reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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F 323	Continued From page 2	F 323		

on 12/28/15 at 9:30 a.m. Resident D was admitted to the facility on 11/21/14. The diagnoses included, but were not limited to, dementia, diabetes mellitus and cognitive communication deficit.

A Social Services Elopement Risk Review was completed on 12/16/14 at 4:22 p.m.,. after the resident was noted to be wandering. This review indicated the resident had memory problems and had a history of purposeful exit seeking and searching for home or something familiar. The review also indicated the resident had been wandering into other rooms and opening doors by restricted areas stating she wanted to leave the facility to get "fresh air." The resident was issued a Wanderguard device (a device to notify staff when at risk residents are near exit doors) at this time and wore it on her wrist.

The current Physician orders, original date of 12/16/14, indicated there was an order written to monitor the individual resident alarm device was in place daily, every day, on the day shift.

The 9/17/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 4. A score of 4 indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident was able to walk in her room and in the corridor with supervision.

The Progress Notes entries indicated the following:
On 11/01/2015 at 3:10 p.m., the Nurse was informed by another resident that Resident #D had pulled the curtain down in her room. The Nurse went to the room and observed the window

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3	F 323		

screen was torn in the middle and a white sheet was hanging from the resident's window. The resident stated she was going to get out the window to get away from bad people. The resident was started on (15) minute checks at the above time.

On 11/5/15 at 1:48 p.m., the resident was moved from her room on the second floor to a room on the first floor.

On 11/25/15 at 10:00 p.m., the Nurse was informed by the 2:00 p.m.- 10:00 p.m. shift CNA (Certified Nursing Assistant) that he could not find Resident #D in her room. Staff began checking both floors. The resident was last seen before dinner.

On 11/25/15 at 10:15 p.m., the Police Department was notified.

On 11/26/15 at 2:30 a.m., the resident was observed at a local restaurant. The resident was taken to a local hospital at this time and the Police were notified of the resident's current location.

A local Police report was reviewed. The report indicated they were contacted on 11/25/15 at 10:53 p.m. by the facility and informed that Resident #D was missing and had left the facility between 6:00 p.m. and 10:15 p.m. on 11/25/15 and the resident suffered from dementia. The report indicated staff reported the resident was last seen at (Location #1, a local grocery store) at approximately 11:15 p.m. on 11/25/15. The report also indicated the resident was found by facility staff at a (Location #2, a local fast food restaurant) on 11/26/15 at 2:35 a.m. and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4	F 323		

been transported to the hospital.

The mileage calculations noted the following:
Lake County Nursing & Rehabilitation to Location #1: 1.3 miles
Location #1 to Location #2: 3.4 miles
Location #2 to Lake County Nursing & Rehabilitation: 3.1 miles.

A facility Incident Report investigation, dated 11/26/15, indicated the Resident #D was not observed during routine bed checks on 11/25/15 and was later located at a nearby restaurant by staff who were out looking for the resident. The entire building and grounds were checked. Staff interviews were conducted related to the incident.

A written statement made by RN (Registered Nurse) #1 (Nurse assigned to care for the resident) indicated Resident #D was last seen before 6:00 p.m. walking up and down the hallway of the first floor on 11/25/15. RN #1 went up the second floor to pass medications and returned to the first floor. At 10:00 p.m. the RN was notified by a staff CNA that they could not find the resident in her room and both floors were immediately checked for the resident. The ADON (Assistant Director of Nursing was in the facility and the DON (Director of Nursing) and the Administrator were notified. The resident was later found at a restaurant on 11/26/15 at 2:30 a.m.

A statement from CNA #2 (the CNA assigned to care for Resident #D on 11/25/15 during the 2:00 p.m.-10:00 p.m. shift) indicated he saw the resident around 6:30 p.m. at meal time. The statement indicated the CNA indicated he was doing rounds around 9:45 p.m. and when he went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5	F 323		

into the resident's room at this time, she was not in her room. The Nurse was told and staff began searching for the resident.

A statement from CNA #3 indicated she responded to the Employee Break Room door alarm on 11/25/15 at 8:15 p.m. The statement indicated the CNA looked outside and did not see anyone, shut off the alarm, and went back to work. The statement also indicated the CNA did not notice her coat was missing at that time.

A statement from the ADON indicated she was present in the facility and was notified by RN #1 that Resident #D was not in the facility and a search was made throughout the facility as well as surrounding grounds outside. The resident was not located. The ADON went with local Police to the gas station nearby and staff there indicated the resident had last been seen 20 minutes prior. The ADON continued her search and at approximately 2:30 a.m., the resident observed through the window of a local restaurant.

A statement completed by the DON (Director of Nursing) indicated she had received call around 10:30 p.m. on 11/25/15 and was notified that Resident #D could not be located in the building. The ADON was instructed to call the Police. The DON received a call from staff who had checked the closest gas station and they informed then they had seen the resident and she was asking other customers for money. The DON later was told the resident had been spotted at the Location #1 and also at Location #3 (a local fast food restaurant) about 20 minutes prior to Location #1 and was seen heading North. The ADON observed the resident at Location #2 and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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F 323	Continued From page 6	F 323		

resident was taken to the hospital to be evaluated for mental status change.

When interviewed on 12/28/15 at 8:39 a.m., Maintenance staff #1 indicated all the exit doors in the facility were to be locked at all times. Staff #1 indicated there were cameras at the Nurses' Station so Nursing could see who was at door and let them in if needed. Nursing staff had to buzz them out. The exit doors were fire doors and if someone pushed on them they would alarm and open. There was a receptionist at the front desk till about 7:30 p.m.

The Maintenance staff further indicated there were four exits and all of them were equipped to alarm when opened. The Maintenance staff indicated they were responsible to check the alarms three times a week until recently and now they were to check more frequently. The Maintenance Staff indicated recently the Administrator placed a binder at the front desk to have ancillary staff complete the checks and sign on the weekends. The Maintenance staff indicated the weekend managers were responsible for completing the checks on weekends when maintenance was not in the facility.

When interviewed on 12/28/15 at 9:58 a.m., the DON indicated Resident #D was to have a Wanderguard in place at the time she was reported missing. The DON indicated the Wanderguard bracelet was cut off and a few days later was found in the laundry. The resident did not have her Wanderguard in place when she was located outside of the facility.

The facility Administrator and the DON were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

interviewed on 12/28/15 at 10:39 a.m. The DON indicated the ADON was in the building at the time and notified her the resident could not be located at 10:30 or 10:35 p.m. The ADON reported they had searched the building and the outside grounds and were not able to locate the resident. The DON indicated she instructed them to check the building again and call the Police. The DON indicated staff later called and informed her they had been going to nearby business places around the building to look for the resident. Staff went to a nearby gas station and was told they had seen Resident #D at the gas station approximately 20 minutes earlier. The DON indicated she also informed another staff member had gone to Location #1 searching for the resident and the store reported the resident had been there about 1/2 hour earlier. Staff also went to Location #3 and staff at Location #3 stated they saw the resident heading towards a gas station. This gas station was one block from Location #3. No one from the gas station reported seeing the resident. The DON indicated the resident was found at Location #2 by the ADON at 2:25 to 2:30 a.m. on 11/26/15. The resident had a staff members coat from the break room.. The resident was taken to the hospital at this time after being assessed by the ADON.

Continued interview with the DON and the Administrator indicated the resident was last seen on rounds by CNA #2 at approximately 6:30 p.m. when he was doing rounds. When CNA #2 was doing rounds 9:45 p.m., he could not locate the resident in her room and informed RN #1. RN #1 indicated she last saw the resident before 6:00 p.m.

The DON indicated the CNA #3 reported she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

heard the alarm sounding outside of the first floor employee lounge at 8:15 p.m. on 11/25/15. The CNA reported she responded to the alarm and looked outside and did not see anyone so she returned to work. The CNA reported she did not inform the Nurse on duty or the ADON who was in the facility at the time. The DON and the Administrator indicated when an exit alarm sounds staff were to respond and check the surrounding area. If no residents were seen a head count of the residents was to be completed at that time to account for all residents and this was not done. A Code Pink for elopement was to be called to search for missing residents and this was not done. The Administrator and DON indicated this exit door was frequently used as it was the staff break room and they would exit to go smoke outside of the exit door.

On 12/28/15 at 11:15 a.m., the above employee lounge room was observed with the DON and the Administrator. The room was at the end of one of the two hallways on the first floor. There was a punch code alarm and a Wander Guard device box on the door frame to exit door to the outside patio area. The door opened and alarmed when pushed on by the DON. There was a brick wall around the patio area with cyclone gates on either side. One gate was locked with a chain and the other was not. The open gate lead to an open area along an alley heading North with a fence on the East side. Another fence intersected and went towards the West. There was a gate on this side of the fence which was not locked. This gate opened directly to an alley. The open area continued towards the front of the Building, the parking lot and a street.

When interviewed on 12/28/15 at 11:25 a.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

facility Administrator indicated residents should be observed every two hours on rounds and this was most likely not done based on the time CNA #2 indicated he had seen the resident in his statement. The Administrator indicated a head count of the residents should have been done when CNA #3 first responded to the exit alarm sounding and no residents or staff were observed outside at that time. The Administrator indicated they no longer allowed staff to smoke outside of the break room after Resident #D had eloped. The Administrator indicated staff could have gotten used to hearing the alarm sounding each time staff went out to smoke.

When interviewed on 12/28/15 at 12:40 p.m., the Director of Nursing indicated 15 minute checks for the resident were initiated on 11/1/15 at 3:00 p.m. after staff found a sheet hanging out from the resident's window. The Director of Nursing indicated 15 minutes checks were completed for three days. The resident was then moved to a room on the first floor and no further incidents were observed.

When interviewed on 12/28/15 at 3:10 p.m., the Restorative/MDS RN indicated the Elopement assessments were to be completed quarterly on residents with Wanderguard devices in place.

On 12/28/15 at 11:25 a.m., the Administrator provided the Elopement and Search (Code Pink) policy, dated February 2014, and indicated the policy was the one currently being used by the facility. The policy indicated all Nursing personnel were responsible for knowing the whereabouts of their residents and were also to make observations of their residents at no less then two hour intervals. The policy indicated in the event

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

that a resident could not be located the Charge Nurse was to announce a "Code Pink" over the paging system. The Charge Nurse was to assign tasks to the staff. The policy also indicated the facility exit door alarms were to be checked daily.

The past noncompliance Immediate Jeopardy began on 11/25/15. The Immediate Jeopardy was removed and the deficient practice corrected by 12/6/15 after the facility implemented a systemic plan that included the following actions: All staff members were in-serviced on the need to complete rounds on each resident every two hours and the current elopement policy which included responding to exit door alarms, observing the surrounding area for any residents, and reporting the results of the observation to the Charge Nurse or management immediately. All staff in-servicing also included review of the Code Pink (missing resident) policy and protocol. The CNA who did not observe the resident every two hours was disciplined. The CNA who turned off the exit alarm and did not report to the Charge Nurse was also disciplined. The facility also implemented a an Alarm Audit binder for Weekend Manager to verify completion of daily alarm checks on the weekends to ensure all alarms were checked daily. This was initiated on December 1, 2015 though no entry was made on the Weekend log on Saturday December 5, 2015. Elopement Risk Assessments were completed for all residents by November 28, 2015. The facility smoking protocol was changed on 11/27/15 and staff were not allowed to smoke outside of the exit door from the Employee lounge area where Resident #D could have eloped from. Staff interviews completed on 12/28/15 and 12/29/15 indicated staff members from various departments and disciplines were aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	C 12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 the current elopement policies and procedures. This Federal tag relates to Complaint IN00188701. 3.1-45(a)(2)	F 323		